

Application Checklist: *Important!* Use this to make sure you send us a complete application. An incomplete application may delay your enrollment if you qualify. **Note:** Do not send this checklist with your application. When you see this arrow ►, it means you may have to send supporting documents.

- ☐ You have reviewed the PCIP and MRMIP comparison charts, which provide information about eligibility, benefits, and costs.
- ☐ You have answered all questions on the application. (**For PCIP**, you must provide your **Social Security Number** if you are a U.S. Citizen or U.S. National.)
- ☐ Send the required documents for the program you are applying for:

*If you choose **PCIP**, include copies listed below:*

► **Proof of a pre-existing condition**, include a copy of one of these:

- ☐ A denial letter from individual (not group) health coverage received in the last 12 months
- ☐ A letter dated within the last 12 months from a licensed doctor, physician assistant or nurse practitioner stating the individual has or had a medical condition, disability, or illness
- ☐ An offer letter of individual (not group) health coverage with premiums that are **higher than the MRMIP PPO rate** based on the area where you live
- ☐ A Certificate of Creditable Coverage letter issued by PCIP from another state or Federally administered PCIP program, (response on page A3 of application)

► **Proof of Citizenship/Immigration Documents**, include a copy of one of these:

- ☐ Certificate of U.S. Citizenship
- ☐ Certificate of U.S. Naturalization
- ☐ U.S. birth certificate
- ☐ U.S. passport
- ☐ Other proof of citizenship
- ☐ Proof of immigration status (Send documents that are not expired. Include copies of both front and back.)

For a list of acceptable immigration documents, go to www.pcip.ca.gov. Then click on the “Frequently Asked Questions” link on the website. Or, call us if you need assistance.

► **Proof of a Name Change**, include a copy of one of these **if your name listed on the application does not match your citizenship or immigration documents**; and you prefer to use your married name, shortened name, or nickname on your application.

- ☐ Unexpired California Driver's License or California Identification Card
- ☐ Marriage License or Marriage Certificate issued from local or state Office of Vital Statistics
- ☐ Legal Name Change document that contains the legal name both before and after the name change
- ☐ Adoption document that contains the legal name as a result of the adoption
- ☐ Dissolution of Marriage document that contains the legal name as a result of court action
- ☐ Domestic Partnership Certificate, Declaration, or Registration document verifying formation of a domestic partnership

*If you choose **MRMIP**, include copies listed below:*

► **Proof of a pre-existing condition**, include a copy of one of these:

- ☐ A denial letter from individual (not group) health coverage received in the last 12 months
- ☐ An offer letter of individual (not group) health coverage with premiums that are **higher than your first MRMIP plan choice** received in the last 12 months
- ☐ A termination letter from a health plan, health insurance company or employer plan for reasons other than fraud or non-payment of premiums received in the last 12 months

► **If applicable, provide copies of the following:**

- ☐ **If you are applying for deferred enrollment** because you believe you qualify but currently have health coverage. Include a copy of a letter from the employer or insurance company you have now, telling us when the insurance coverage will end.
- ☐ **If you currently have Medicare Part A and Part B because of end-stage renal disease**. Include a copy of the approval letter from Medicare.
- ☐ **If you want to waive part or all of the waiting or exclusion period**. Include a copy of proof of any insurance coverage that you had before.
- ☐ **If you have a dependent child who is over 23 years old**. Send a doctor's letter with the application for each child over 23 stating that the person cannot work because of a continuous physical or mental disability that started before age 23. The dependent child cannot be married.

- ☐ Sign and date the application.
- ☐ Write a check for one month's premium for the program you are interested in. Make the check payable to the **Managed Risk Medical Insurance Board (MRMIB)**. See pages 10– 15 for the programs' monthly premiums based on your age and where you live.
- ☐ Mail the application with your check and all required documents to:
California Pre-Existing Condition Insurance Plan, P.O. Box 537032, Sacramento, CA 95853-7032

Note: Insurance Agents/Brokers or Certified Application Assistants must complete **all applicable** boxes at the bottom of the application on page A4 to request and receive payment.

Section 1101 of the Patient Protection and Affordable Care Act, Public Law 111-148 and Insurance Code Sections 12739.52(e), 12711(a), authorizes the programs to collect and maintain the information solicited in this application.